TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
AHMED KHALIFA MD

**Respondent Name**
AMERICAN ZURICH INSURANCE COMPANY

**MFDR Tracking Number**
M4-18-0347-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
October 12, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "There has been no payment issued on this claim and therefore, the total amount due is noted on the [sic] on the original HCFA claim form as attached to this Request for Reconsideration."

**Amount in Dispute:** $172.67

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The date of service in question is November 10, 2016, for an office visit under CPT code number 99214. You should have a copy of the provider's DWC-60 packet. We are relying upon records from that packet in addition to the carrier's EOB dated December 15, 2016. The provider is not entitled to reimbursement. The ANSI code B7. The provider was not certified-eligible to be paid for this service/procedure on this date of service."

**Response Submitted by:** Flahive, Ogden Latson

## *SUMMARY OF DISPUTED SERVICE(S)*

| Date(s) of Service | Disputed Service(s) | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 10, 2016 | 99214 | $172.67 | $172.67 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

### Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system .
3. 28 Texas Administrative Code §133.3 sets out the guidelines for Communication Between Health Care Providers and Insurance Carriers.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service

## Issue(s)

1. Did the insurance carrier issue a sufficient explanation for denial of CPT Code 99214?
2. What are the communication guidelines between the healthcare provider and insurance carrier?
3. What is the definition of CPT Code 99214?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. Is the requestor entitled to reimbursement?

## Findings

1. The requestor seeks reimbursement for CPT Code 99214 rendered on November 10, 2016. The insurance carrier denied the disputed service with denial reduction code "B7" (explanation provided above). Review of the requestor's position summary addresses the billing of CPT Code 99204, which is not identified as a disputed service on the "Table of Disputed Services." Although the requestor submitted a detailed position summary, the position summary addressed reasons for reimbursement that were not raised by the insurance carrier during the medical bill review process and were not indicated on the EOBs presented to MDR. The Division will therefore review the disputed service based on the insurance carrier's denial reason.

2. 28 Texas Administrative Code §133.3 (a) sets out the communication guidelines between the healthcare provider and the insurance carrier and states in pertinent part, "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as 'insurance carrier improperly reduced the bill' or 'health care provider did not document' or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section The respondent submitted a copy of an internal 'Review Analysis' containing several new claim adjustment codes and denial reasons. The additional claim adjustment codes and denial messages do not match the explanation of benefits submitted by the requestor (as enumerated in the Background section above)."

   Review of the EOB presented by the parties finds that the insurance carrier did not meet the requirements of 28 Texas Administrative Code 133.3. Specifically, the EOB presented to MDR was not sufficient and did not contain specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. The Division finds that the generic statement presented to the healthcare provider during the medical bill review process was insufficient for the Division to identify the reason for the insurance carrier's denial of the disputed service. The Division will therefore consider whether the requestor rendered the services as billed.

3. The requestor seeks reimbursement for CPT Code 99214 rendered on November 10, 2016. The AMA CPT Code book defines CPT Code 99214 as follows "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family." Review of the documentation presented by the requestor supports the billing of CPT Code 99214. As a result, the requestor is entitled to reimbursement for the disputed service.

4. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   Procedure code 99214, service date November 10, 2016, is a professional service paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 1.5285. The practice expense (PE) RVU of 1.42 multiplied by the PE GPCI of 1.006 is 1.42852. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.955 is 0.0955. The sum of 3.05252 is multiplied by the division conversion factor of $56.82 for a MAR of $173.44. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $172.67.

5. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $172.67.

## Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $172.67.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $172.67 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## Authorized Signature

| | | |
|---|---|---|
| | | November 10, 2017 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.